



GUARDIAN

Please Print clearly and in Black or Blue ink

Please Print in Capital Letters only

ENROLLMENT/CHANGE FORM

Planholder Name (Company Name) Group Plan Number Division Class

PLEASE CHECK APPROPRIATE BOX

Initial Enrollment/Refusal of Coverage (Complete Sections 1, 3, 4, 6)
Add Employee/Refusal of Coverage (Complete Sections 1, 3, 5, 6)
Add Spouse
Add Children
Newborn
Previously refused this coverage
Adoption Date
Loss of Other Coverage

Drop/Refuse Coverage (Complete Sections 2, 4, 6)
Drop Employee (Complete Section 4)
Drop Dependents (Complete Section 4)
The date of withdrawal cannot be prior to the date this form is completed and signed.
Termination of Employment
Retirement
Last Day Worked
Last Day of Coverage
Other

SELECT COVERAGE(S): Dependents cannot be enrolled for coverage refused by the employee.
Medical
Life
AD&D
Dental
Vision
Long Term Disability
Short Term Disability
Buy-Up
Flex Ability Guard
PPO
Indemnity

SELECT COVERAGE OPTIONS: Choose only one option for each coverage.
Medical
Dental
LTD
STD
Buy-Up
Flex Ability Guard
PPO
Indemnity
* Complete Pre-Paid Office # in Section 6
* Buy-Up (up to 50% of salary)
* Flex Ability Guard (up to 50% of salary)

REFUSE/DROP COVERAGE(S):
Medical
Life
AD&D
Dental
Vision
Long Term Disability
Short Term Disability
Buy-Up
Flex Ability Guard
Other
I have been offered the above coverages and wish to refuse/drop enrollment for the following reasons:
(additional information may be required)

LOSS OF OTHER COVERAGE:
Spouse/my dependents were previously covered under another group plan. Loss of coverage was due to:
Termination of Employment
Divorce
Death of Spouse
Term/Expiration of Coverage

Employee Name, Add, Drop, Last, MI, Sex, Birth Date, Social Security Number, State, ZIP, City, Home Phone, Marital Status, Are you: Actively at work, Retired, Other, Occupation/Job Title, Annual Salary, Date of Full Time Hire, MI, Sex, Student, Birth Date, Social Security Number, Pre-Paid Office #

Spouse Name, Child Name, Child Name, Child Name, Child Name, A) Have you included stepchildren?, B) Is this your first eligible child?, Relationship, Name

Beneficiary Designation: (include full proper name and relationship) Name:
Applicable to Accident and Health Coverage
Information, or conceal for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Signature:
Date (MM DD YYYY)
GG-013978NY 3/02
Please return completed form to Bethlehem Chamber